

An Independent Study of the Administration of
Involuntary Non-Emergency Medications
Under Act 114 During 2005

Report to the Vermont General Assembly

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And

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INTRODUCTION

Act 114 is the Vermont statute governing the administration of involuntary non-emergency psychiatric medications to clients of the public mental health system committed to the care and custody of the Commissioner. The statute requires an annual independent review of its implementation. Implementation of Act 114 commenced in late 2002. To date, there have been two annual reports providing assessment of Act 114 implementation; this is the third such report and reviews implementation during 2005.

During 2005, 13 individuals received involuntary non-emergency psychiatric medication under the provisions of Act 114. This compares to 27 individuals in 2004 and 15 individuals in 2003. All those receiving involuntary non-emergency psychiatric medication were hospitalized at Vermont State Hospital (VSH) at the time of the court order and receipt of medication.

This report, in compliance with statutory requirements for the annual independent assessment, provides the following information:

1. An evaluation and critique of the performance of VSH and its staff in the implementation of Act 114 provisions for 13 persons receiving involuntary medication in 2005.
2. A summary and analysis of what resulted based on interviews with persons involuntarily medicated under the provisions of Act 114. While the statute includes family members, as discussed, none of the persons interviewed wanted family members to participate.
3. A review of steps taken by the Division of Mental Health, Department of Health (DMH), to achieve a mental health system free of coercion.
4. Recommendations for current practices and/or statutes.

Flint Springs Associates, a Vermont-based firm specializing in social policy research, assessment and planning, conducted this assessment. Flint Springs' senior partners, Joy Livingston, Ph.D., and Donna Reback, MSW, gathered needed information, analyzed the data, and developed recommendations reported here. Marty Roberts, a consumer advocate, played a critical role in recruiting persons who had experienced involuntary medication under Act 114 to participate in the assessment.

Information for this report was gathered through a review of VSH documentation, DMH data, and interviews with and feedback from:

- VSH staff (administrators, psychiatrists, nurses, social workers, and psychiatric technicians)
- DMH administrators
- Recipients of involuntary medication under Act 114 during 2005

VSH Performance Implementing Provisions of Act 114

During the calendar year 2005, 22 petitions were filed requesting orders for non-emergency involuntary medication under the provisions of Act 114. In all cases, petitions were sought by VSH staff psychiatrists and sent through the Attorney General's DMH office to the court. Of the 22 petitions, six (27%) were withdrawn, two (9%) were denied, and 14 (64%) were granted. One individual had two orders granted, so a total of 13 individuals had orders for non-emergency involuntary medication in 2005. Table 1 provides information on the number of filings for court orders over the past three years during which Act 114 has been implemented. As the implementation time period is limited to three years, it is not clear if the spike in number in 2004 represents an unusually high number of cases or the lack of trends over time.

Table 1: The number of cases filed in which orders were granted, denied, or filings withdrawn during the three calendar years in which Act 114 has been implemented

Cases Filed	CY 2003	CY 2004	CY 2005
Granted	15 (68%)	29 (88%)	14 (64%)
Denied	2 (9%)	1 (3%)	2 (9%)
Withdrawn	5 (23%)	3 (9%)	6 (27%)
Total	22	33	22

The Act 114 statute requires the Division of Mental Health (DMH) to “develop and adopt by rule a strict protocol to insure the health, safety, dignity and respect of patients subjected to administration of involuntary medications.” VSH had in place a protocol and set of forms intended to guide personnel in adhering to the protocol. The 2004 assessment found that the forms were not completed consistently, so there were missing records documenting implementation of the protocol. We recommended several changes to the documentation procedures, including development of checklists and training staff. VSH staff worked to clarify the protocol and streamline the documentation process to provide clearer, more consistent evidence of protocol implementation. This process was completed and implemented in April, 2005.

The protocol is now outlined in a written, specific step-by-step document entitled “Vermont State Hospital Court Ordered Medication Steps.” This document outlines in explicit detail forms that must be completed, by whom and when they must be completed, and to whom copies are distributed. The Medical Records Specialist's roles to ensure that documentation is complete and updated are clearly outlined. Act 114 packets have been developed which include a set of needed forms and a checklist to guide staff on the protocol and documentation. Forms include:

- Patient Information Form
- Implementation of Court Ordered Medication Form
- 30 Day Review of Court Ordered Medications Form
- Certificate of Need (CON) packet

Medical Records developed a Support Person Letter to use if a patient requests that a support person be present at administration of medication. The letter is used as a follow-up after staff contact the support person. The letter names the staff member who was in touch with the support person and records whether the staff person was able to talk with the support person, able to leave a message, or unable to make contact. The letter then provides expected date and times of medication administration. It provides the name and contact number for the patient's physician and indicates whether or not the patient has given the physician permission to provide the support person with additional information.

The protocol includes a requirement that each patient on court-ordered medication have a separate file folder maintained in Medical Records including:

1. Copy of court order
2. Copy of Patient Information Form
3. Copies of every Implementation of Court Ordered Medication Form
4. Copy of 30/60/90 day reviews
5. Copies of form letter used to contact patient-identified support person
6. Copies of CON if needed
7. Summary of medications based on court order
8. Specific timeline of court order based on language of court order

The following section provides descriptions of the four key forms included in the Act 114 packet and summarizes what was learned from our review of this documentation.

Description of Protocol Forms

Patient Information Form

The Patient Information Form was updated in 2005 to include additional information about requests for support persons and gender preferences if medication is to be administered by injection. Additionally, a patient signature was added, with a check-box to document patient refusal to sign the form.

The treating physician completes and reviews this form with the patient before implementing an order for involuntary medication. The form includes information on the medication (type, dosage, frequency, how it will be given, intended effect, possible short-term side effects, uncommon long-term side effects, rare potential side effects, potential interactions with other medications/drugs/alcohol, and potential effect on pregnancy/fetus/nursing child). It also includes check boxes to indicate whether the patient does or does not wish to have a support person present; if a support person is requested there is space to include the person's name, address and phone number. There are also check boxes to indicate, if an injection will be needed to administer the medication, the patient's preference for attending professionals' gender (i.e., male, female, no preference). Finally, the treating physician signs the form and the patient is asked to sign; if the patient refuses to sign, there is a check box to so indicate. One copy of the form is for the patient, another is kept in the patient's record and a third is sent to medical records.

Implementation of Court-Ordered Medication Form

The Implementation of Court-Ordered Medication Form was updated to incorporate information from two previous forms used to document administration of oral and injectable medications. Documentation of patient's request for support persons was added to the form, as well as a section on gender preferences. In addition, an instruction statement was added to ensure documentation is completed every time a court-ordered medication is administered. Guidelines for implementing court-ordered involuntary medication are included on the back of the form reviewing patient rights and protocol on support persons, administration of oral and injectable medication, and observation and documentation of side effects.

This form is completed and signed by the "medication giver" every time involuntary medication is administered. One copy is kept in the patient's record, the other is sent to medical records. The form includes: check-boxes to indicate whether or not a support person was identified on the Patient Information Form, and if so, whether that person was present. If the person was not present, there is a line to record the reason. There is a section for oral medication, including whether oral medication was offered to the patient, the medication administered (including type, dosage), and whether a mouth check was performed, and if so whether the patient was compliant with the mouth check. There is a section for injectable medications, including medications administered (type, dosage), patient's preferred injection site, whether that site was used and if not, why, patient's preferred gender of health professional, name of accompanying health professional and gender, and whether restraints were used during administration of medication (if so, instructions to complete a CON). The medication giver signs the form and indicates his/her gender, time and date of administration.

30 Day Review of Non-Emergency Involuntary Medications by Treating Physicians

This form was revised to include sections for physicians to address whether or not there is a need to continue use of involuntary medication. In June of 2005, the form was again revised to include check-boxes for review and auditing by the Medical Director and Legal Department.

The form is completed and signed by the treating physician, with one copy for the patient's record and another for medical records. The form includes the order and review dates, as well as responses to the following prompts: current medication, dose, frequency and route of administration; effects/benefits of medication; side effects and treatment of side effects; evidence for need for continued implementation of involuntary medication court order, or reason order for involuntary medication is no longer needed. The 30 Day Review is to be completed once a month during implementation of court-ordered non-emergency involuntary medication.

Certificate of Need (CON) Form

The CON form first asks for a description of the Emergency Involuntary Procedure (EIP) used. Several types of restraint and seclusion are listed, with a column following what? to record the start and end time of the procedure. A note in large font reminds staff that

“restraints and seclusion require constant observation of patient.” The form then provides check boxes to describe the reason for the procedure, and an open-ended question asking for a description of the circumstances leading to and contributing to loss of control/escalation in behavior. Next, a set of check boxes is provided to identify de-escalation measures attempted before using the EIP. The person initiating the procedure signs the form. The next section of the form requests a nursing assessment or comments at the beginning of the procedure, and then provides check boxes to record whether the patient continued to be threatening or self-harming, or other. The form then provides a set of prompts on orienting the patient to the necessity of EIP and how the procedure might be discontinued. The form asks if the patient wanted someone to be notified of the use of EIP, and if so, provides space to record the person’s name and contact information. The nurse must sign the form. The form continues with a section for the covering or attending physician to complete, asking if there was a meeting to debrief other patients on the unit, and if not, why not. The physician also must sign the form. The rest of the form includes sections to prompt staff on debriefing for the patient, and among the treatment team. If debriefing was not included, reasons why not are requested. The form ends with questions about frequency of EIP for this patient, requesting a written report if the procedure has been used recently.

Review of Documentation Using Protocol Forms

To assess the implementation of the Act 114 protocol, we reviewed forms completed by VSH staff for the 13 persons receiving involuntary medication during 2005. Medical records provided copies of relevant forms from each of the 13 persons’ files, removing all identifying information to protect patient confidentiality.

Patient Information Form

For 12 of the 13 patients (92%), completed patient information forms were present. Half of these were the old (pre-April 2005) forms, so did not include all the information present in the revised forms. The patient who did not have a form was under a court order that commenced prior to revision of the protocol. Since implementation of the new protocol, all patients had completed forms. It appears that physicians now more consistently use the new forms. Of the six new forms, three (50%) indicated that patients refused to sign the form.

Implementation of Court Ordered Medication Form

We looked at the forms documenting the first three administrations of involuntary medication following the court order, and then at the forms used for administration of medications at 30 days and 60 days following the court order. In all but one case, implementation forms were present. Again, this was a patient for whom the court order for medication was prior to April, 2005. In 12 case files (92%), forms were present for each administration of involuntary medications. Old forms were used in cases where the order occurred prior to April, 2005; if administration of involuntary medication continued past that date, new forms were utilized. The forms were nearly all complete; in three

cases (6% of the 51 forms) check boxes for mouth check in administration of oral medications were not marked.

30-Day Review of Non-Emergency Involuntary Medications by Treating Physicians

All patients who remained on court-ordered medication for at least 30 days had copies of needed 30-Day Reviews. One patient started taking medication voluntarily prior to the 30 days so did not have this form. All 30-Day Review forms were complete.

Certificate of Need (CON) Form

A CON was needed once in the administration of medication. The form was complete and described the use of hands-on to guide a patient to a room in which to receive medication.

Staff Feedback on Implementing Act 114 Protocol

Act 114 Implementation Training

Psychiatrists have received additional training with the establishment of new procedures for documenting implementation of Act 114. The training reviewed provisions of Act 114, with specific attention to the right for a support person, naming of medications, and strategies used prior to seeking a court order. A new orientation and book has been developed for medical staff that includes information on implementation of Act 114. Social workers, nurses, and psychiatric technicians did not report any new Act 114 training, but indicated that physicians were responsible for ensuring adherence to the protocol.

Decision to File Order

Decisions to pursue an order for involuntary medication continue to be made in the same manner as in past years. This is a decision made by the treating physician, in discussion with the treatment team.

Patients' Rights

Act 114 outlines several specific aspects of patients' rights that must be addressed when administering non-emergency involuntary medication. Psychiatrists reported that, while not a new strategy, they try to engage family members and other support persons in understanding the provisions of Act 114. The psychiatrists have the primary responsibility of talking with patients about orders for non-emergency involuntary medications, and discussing provisions of Act 114, as outlined in the Patient Information Form. The doctor may include other team members in this conversation if that might be deemed helpful.

Patients have the right to a support person present during administration of medication. The new patient information form specifically documents whether or not a support person

was requested. Psychiatrists report that if they are able to discuss this right with patients, they do so. Other staff members said that this conversation was between the patient and doctor; however, many offered that patients often do not remember what they have been told when they were very agitated.

In order to increase a sense of control for patients receiving involuntary medication, the nurse and psychiatric technician staff members will ask patients if they would like to choose the time of day to receive their medication (if this is possible), who they would like to administer the medication, in what room they would like to receive the medication, whether they want to receive the medication orally, and so on. Many times patients are asked if they would like to schedule an appointment for the medication. Nurses and psychiatric technicians report that the opportunity to schedule an appointment works well for many patients. Social workers report that the entire goal of treatment is for people to regain control over their lives, so with involuntary medication they encourage patients to talk with their doctors about any problems they are having with the medications and alternative medications that they can try. Psychiatrists concur with the social workers and see involuntary medication as one tool to help restore people's autonomy. Within the scope of involuntary medication, psychiatrists try to provide as much latitude to patients as possible, including use of oral medication and types of medication. Both social workers and nurses said that the court orders were often too restrictive to allow patients to make choices between types of medications or whether to take the medication orally. However, doctors noted that they had worked with the legal division to change the language of court orders so that there was more flexibility in type and administration of medication.

Patient Involvement

Patient involvement in treatment planning has been discussed in past assessments. Beginning in 2003, VSH staff reported that efforts were being made to improve patient involvement in treatment planning. For the 2005 assessment, VSH staff again spoke of their efforts to include patients in treatment planning. Physicians reported that a great deal of effort is made to include patients in the treatment team meeting, and if these efforts are not successful, then members of the team have conversations with the patient so that the patient can articulate perceived problems and goals. Social workers noted that the weekly treatment team meets without the patient, but that monthly review meetings do try to include the patient. All staff members noted that effort is made to listen to and reflect patients' values and beliefs, including spiritual beliefs and views on treatment. Nurses pointed out that the "name of the game is getting patients involved."

We examined initial treatment plans developed at hospital admission and plans developed following first administration of involuntary medication. In 2005, all plans were complete and indicated whether or not patients had been involved in the development of the plans. The majority of patients had been directly involved in the initial treatment plan, up from 2004 (see Table 2). If not directly involved, patients were indirectly involved, generally meeting with team members individually. Only one patient refused to be involved in the initial treatment plan. At the first treatment plan review, again the majority of patients were involved directly, both in 2004 and 2005. In 2005, of the three

patients not involved, two refused to be involved and one patient did not speak English and an interpreter was not available.

Table 2: The Number of Treatment Plans indicating Patient Involvement

	Patient Directly Involved	Patient Indirectly Involved	Patient Not involved	Total
2004				
Initial Plan	8 (30%)			27
Follow-up Plan	14 (52%)			27
2005				
Initial Plan	9 (69%)	3 (23%)	1 (8%)	13
Follow-up Plan	9 (69%)	1 (8%)	3 (23%)	13

Individualized Emergency Plan

In the 2004 assessment, VSH medical staff noted that when a person enters the hospital, the treatment team talks with him or her about what to do if an emergency happens and then tries to build an individualized emergency plan. The 2005 interview with physicians indicated that Individualized Emergency Planning is not typically part of Treatment Planning; rather it is part of the admissions process with nurses. Social workers agreed that emergency planning was generally part of the nursing assessment process. Social workers noted that some patients enter the hospital with a crisis plan that may be included in their treatment plan. They also said that not all patients are able to create an emergency plan at admission. Nurses confirmed these statements, saying that there is a question on the initial nursing assessment conducted at admission which asks about emergency procedures, including past experiences and things the staff should know. This information is included in the patient's electronic file, available for the treatment team to review. In addition, nurses noted that some patients enter the hospital with a behavior plan which outlines steps to decrease agitation and manage their behavior.

We examined the initial Nursing Assessment for all patients receiving involuntary medications under the provisions of Act 114 during 2005. There are two relevant questions we reviewed: one requests information about any approaches to being anxious or upset that have "helped you to control your behavior in the past" and the other asks "if there is anything you would like staff to know about that might affect you" if there is a need to use seclusion or restraint. Eleven (85%) patients were asked these questions, and of these eleven, 6 (55%) were able to provide answers. One patient's nursing assessment form did not include the questions. Another patient was not asked the questions because of a language barrier.

CON and Emergency Involuntary Procedures

In the 2004 assessment we learned that VSH had instituted a new Certificate of Need (CON) form which provides staff members with a set of prompts and debriefing questions designed to provide more structure and consistency, towards the goal of reduced use of Emergency Involuntary Procedures (EIP). Physicians reported that the

new CON form was working well and had resulted in a decreased use of restraints and seclusion. Indeed, as shown in Table 3, the average number of involuntary procedures was consistently lower in 2005 than in 2004. Administration of non-emergency involuntary medication required submission of a CON on only one occasion; in this incident, minimal hands-on restraint (i.e., a hand on the back) was needed to guide the patient to a room.

Table 3: Monthly Average Number of Emergency Involuntary Procedures (EIP)

Year	EIPs involving Seclusion		EIPs involving Restraint		EIPs involving Emergency Involuntary Medication	
	Average Number per Month	Average Number per Month removing top outliers*	Average Number per Month	Average Number per Month removing top outliers*	Average Number per Month	Average Number per Month removing top outliers*
2004	37.42	13.08	26.67	10.58	41.25	21.42
2005	25.33	12.22	15.67	8.67	31.11	18.56

* Top outliers: There were multiple uses of EIPs for a few individuals; these individuals are the outliers. The average number of EIPs with these outliers removed represents the number of EIPs for the remainder of the patient population.

Physicians reported that emergency involuntary medications were being used with patients not otherwise receiving medication. The CON form seems to have been part of a process in which VSH staff attempt other strategies prior to using emergency procedures. The physicians felt that the more explicit and detailed debriefing process helped in this effort. And they also credited the Treatment Review Panel (including a psychiatrist, psychologist, social worker, nurse, and consumer) with providing effective outside review, including assessment of staff and patient injuries.

Nurses and psychiatric technicians felt that the decreased use of seclusion and restraint was a result of increased staffing, which allowed staff more time to spend with patients individually. This increased individualized time with patients has allowed staff to address issues sooner; agitated patients are given one-to-one attention immediately, rather than after use of involuntary procedures. Nurses and psychiatric technicians also felt that staff education had contributed to the reduced used of involuntary procedures. Staff members had become more skilled in using spoken interventions to defuse situations, rather than relying on seclusion. Nurses reported that the new CON form collected important and needed information (e.g., strategies attempted prior to using involuntary procedures), but the form was difficult to complete and not user-friendly.

While psychiatrists attributed the reduced use of involuntary emergency procedures to the introduction of the new CON, including the debriefing process, and input from the Treatment Review Panel, nurses and psychiatric technicians attributed this improvement to staff education and increased staff-to-patient ratio.

Benefits and Challenges of Act 114

We asked VSH clinical staff to identify and discuss the benefits and challenges resulting from implementing the provisions of Act 114. As in past years, all staff members agreed that administration of involuntary medication was a method of last resort. Psychiatrists said that use of 114 was, in essence, a failure to engage. They felt the spike in numbers of patients receiving involuntary medication in 2004, as compared to 2003 and 2005, was a result of “an enormous number of people who could not be encouraged to use medication,” not a reflection of anything they were doing differently. The strategy for psychiatrists is to engage patients in their recovery.

Staff members shared a concern about the patients who remain in the hospital for extended time periods without medication. Psychiatrists mentioned that in some situations a Durable Power of Attorney (DPOA) can serve as a barrier to receiving court-ordered involuntary medication, leading to long hospitalizations without medication. The doctors cited one example of a patient who remained hospitalized for years because the guardian and attorney, operating under the DPOA, did not agree to medication. Social workers also talked about the frustration of seeing patients’ lives dissolve while waiting for medication. They noted that involuntary medication is never a good experience, given that it is involuntary; yet, treatment does make a difference and it would be better to provide treatment sooner rather than later. Psychiatric technicians and nurses also spoke about how difficult it was to see people lose so much of their lives (i.e., home, family, jobs), and suffer brain damage as they wait to get medication. Nurses pointed out that patients without medication may also refuse treatment for medical conditions such as high blood pressure, adding to their suffering. All staff members agreed with the importance of taking civil rights seriously, but felt that the time delay to treatment was inhumane. Psychiatrists noted that the Treatment Review Panel has recommended creation of a mechanism that would decrease the amount of time between admission and receipt of medication.

As in past years, staff members were concerned about patients’ experiences once they return to the community. If they return to the community and stop taking medication, then the whole process of decompensation, hospitalization and court process repeats, contributing to continued loss and suffering. Social workers suggested that court orders for non-emergency involuntary medication continue when people return to the community; for example, an individual could return to the hospital for an injection and then return to the community.

Outcomes from the Perspective of Persons Receiving Involuntary Medication

Participation

As noted earlier in the report, 13 persons received court-ordered involuntary medication under Act 114 in 2005, representing a significant decrease from 2004, when 27 persons received involuntary medication. We received feedback from four of those individuals medicated in 2005. While this is a decrease in raw numbers from the six individuals who talked with us last year, proportionally the percentage of persons providing feedback rose from 22% in 2004 to 31% in 2005.

Over the three years in which this evaluation has been conducted, there has been a steady and significant increase in feedback from individuals who received medication under Act 114. We continued our efforts to increase participation and believe that the steady climb in participation rates from 2003 to 2005 resulted from implementing the recommendations laid out in the 2003 evaluation report. These included the following steps to engage individuals – and their family members - in this study:

- A consumer-advocate, well known and highly regarded in the consumer community, was hired by the consultant team to talk with individuals interested in learning more about the study, answer their questions, and refer interested parties to the consultant conducting interviews. A toll-free phone number was provided to make it as easy as possible for people to contact this person.
- Compensation of fifty dollars (\$50.00) was offered and paid to individuals who chose to be interviewed.
- A brochure, intended to inform people and create interest in participating, was written and distributed to the Community Rehabilitation and Treatment Directors across the state who, in turn, posted these in their agencies.
- The Vermont Legal Aid Mental Health Law Project mailed a packet of information to each individual under a court-order for involuntary medication. This packet included a letter and the brochure referred to above, discussing the study, describing how one could get more information about the study, and offering compensation for participation.
- Notices were posted in two publications of Vermont Psychiatric Survivors, “Survivor” and *Counterpoint*, informing readers of the project, the opportunity to be interviewed and the compensation, and giving people the toll-free number and name of the contact person from whom they could get more information.
- Contact was made with the Executive Director of the National Alliance for Mental Illness of Vermont (NAMI—VT) for the purpose of eliciting feedback from family members of persons who received involuntary medication.

Two additional steps were taken to recruit participants in 2005, specifically:

- Brochures describing the evaluation were made available along with an announcement to conference participants at NAMI—VT’s annual meeting.

- The Mental Health Law Project sent out a second follow-up letter with brochures to individuals who received medication under Act 114.

Focus of Interviews

Persons interested in giving feedback were given the choice of being interviewed over the phone or in person. Two persons were interviewed in face-to-face settings and two persons provided their perspectives via phone interviews. None of the persons who were interviewed expressed an interest in having family members participate in this part of the evaluation.

In accordance with the desire of the legislature to evaluate the implementation of Act 114, the interview questions focused on understanding:

- Conditions and events leading up to the involuntary medication
- Conditions and events related to the actual experience of receiving involuntary medication
- Each individual's view of what was most and least helpful
- How well individuals were informed regarding how and why they would be receiving involuntary medication
- Whether and how individuals were apprised of their rights to have a support person present and to file a grievance
- Recommendations individuals had for improving the process of administering involuntary medication

Findings from People Receiving Involuntary Medication under Act 114

Information about court hearing

Interviewees' experiences and recollections differed. One person reported that he was told about the court hearing by his court-appointed lawyer a couple of days prior to receiving the medication. One individual could not remember if and what he had been told about the hearing. A third person reported he was told nothing about the court hearing and a fourth did not give a clear response to the question.

Understanding of the reason for the involuntary medication court order

One person said that he was incompetent at the time of the court order which led to receiving the medication. Another understood that he was delusional. A third interviewee felt strongly that he was sane and disagreed with the assessment that he needed medication. The fourth person did not accept or reject that he needed the medication, but said he did not want to take medication because of the side effects he had previously experienced with psychotropic medications including bodily pain, lethargy, increased paranoia and significant weight gain.

Information about the court order

Two people said they were told the court had issued an order for them to receive involuntary medication. One was given this information by a physician and one reported being told by a nurse – both at the state hospital. A third person said he was not told there was an order and the fourth person said he was told by his public defender.

Information about court ordered medication

Two individuals interviewed reported that at some point around receiving involuntary medication, they received information about the medication they were receiving including what it was (its name), dosages, and side effects. One of the two reported he had been told everything that was relevant. However the other person reported that he hadn't been informed of all the side effects and subsequently experienced severe dehydration, headaches, weight gain and sleep disorder, all of which he associated with side effects of the medication.

A third individual said he had been told nothing, but was placed on medication he was familiar with through previous experiences.

One person said that not much was explained to him regarding the medication. This person believed that he did not need to take medication and reported that he is “so full of medication over his lifetime” and finds that any more medication upsets his system.

Information about Act 114 protocols including the right to file a grievance

The four respondents reported they were unaware of and had not been told anything about the Act 114 Protocol. Three individuals reported they did not know of their right to file a grievance. The fourth person said he was not told of this right or anything about the protocols, but he assumed that since he was in a state institution he had a grievance right.

Choices leading to method of receiving medication

Three of the respondents chose to take medication orally. Two people reported they made this choice because they did not like injections. The third person said that at some point he stopped taking the medication. At that point, the hospital staff took away his smoking privileges. This in turn made him decide to comply with the medication order and he resumed taking it orally.

The fourth individual said that he had begun taking the medication orally but was observed spitting the pill out. In response he was given shots “for a few days” and then he agreed to take the medication orally.

Offer of and desire for a support person

All four said they had not been asked if they wanted a support person present when receiving the medication. Two of those persons said if they had known about that right, they still would not have exercised the option. One person, however, said that he would have requested that someone be there to act as a witness.

Setting in which medication was administered

All four respondents ultimately received the medication at the medication window at the state hospital. However, two of them were unclear about where in the hospital they received it when the order was first implemented. One individual said that initially he received the medication in his room.

In response to questions about the adequacy of the setting in terms of their desire for privacy, three people said that privacy wasn’t an issue for them. However, one of those said that he had no idea that he had the right to request a more private setting. The fourth individual stated that he would have preferred receiving the medication in his room all the time.

Treatment by staff during and after administration of involuntary medication

Respondents were asked a number of questions regarding their assessment of how hospital staff treated them during and after receiving involuntary medication.

Re: respect, dignity and safety – Two individuals stated that they had been treated with respect, and one of these persons used the term “professionally” in his description of staff treatment toward him. The other individual noted that his temper had flared at times during this hospitalization and that he had a history of being assaultive. He reported that, in response, hospital staff chose not to restrain him (as had happened in the past). Instead they put him in the seclusion room to calm down and become compliant. He viewed this response as an indicator of being treated with respect.

In two cases, individuals specifically stated that staff dispensing medication were “courteous” and did treat them with “dignity and respect.” “Staff” were defined as psychiatric technicians and nurses. However, those same two persons reported displeasure with the way that doctors had treated them. One person reported that “the doctor who gave me the medication was adamant and didn’t listen to my complaints and ...wasn’t open to my concerns”. The other felt that the doctor ordered him, in an unfriendly manner, to take his medication.

A third person felt that his treatment varied depending on which staff person was dealing with him. He reported that his doctor periodically “threatened” him with getting an injection if he didn’t comply with his medication order.

A fourth respondent felt that staff on the day shift were more competent in administering shots than the night staff. When receiving injections, he reported, “no one kept an eye on” him immediately after the shot.

Re: receiving emotional support - Three people reported they felt they received no emotional support from staff around receiving medication. One of the three reported that the staff were unsympathetic, especially to the side effects he experienced. A fourth respondent said that the “psych tech” stayed with him and while his presence “didn’t matter” he didn’t find it offensive. Later in the interview this person said that hospital staff “did a good job.”

Re: debriefing after receiving involuntary medication - We asked respondents whether, after receiving involuntary medication (especially in the beginning), hospital staff talked with them about the experience in an effort to debrief, help people understand what happened, answer questions and generally process their feelings. One person did not remember. However, three individuals definitively reported that no one offered to talk about the experience. One of these felt that staff should have – he said it “would be helpful to be informed about what this was about – would have liked to have had it explained exactly....give the person the paper work to read so they know exactly what would happen, what the medicine does to you. Would be good to receive this information before taking the medicine so you will know what to expect...inform the person....this makes them less apprehensive...so you would have in your mind what would happen to you”.

Re: gender of persons giving medication - None of the four respondents felt that the gender of the person administering the medication was important to them but it appears they weren’t asked.

Re: extent to which wishes were respected and sense of having some control over what was happening – One respondent reported that his doctor worked with him around trying a couple of different medications to see what would work best for him. He felt that together he and his doctor reached some agreement and this process “gave me a sense that I had a choice.”

The three other individuals interviewed reported a different experience. Two were adamant that they had no control over what was happening. One of the three noted that the “only time I had control was when I chose not to take (the medicine)”. But then, he said there would be consequences. He said that he asked for medication to boost his energy and curb his appetite, but there was no openness to his suggestions. Another of the three said he had been told if he took the medication he’d be out of the hospital within 21 days. However, 30 days later he was still hospitalized.

Re: extent of force used to get people to take medication – Three people responded to this. One person described his first experience receiving the medication. It was

administered by injection and he was in the seclusion room. At that time eight people (staff) were outside the room. He felt intimidated by that. Subsequent injections were administered by one person with no one else around.

A second person reported that he felt forced to take the medication – he knew if he refused he'd receive it via injection and he “didn't want to take it by needle” so he agreed to take it orally.

The third respondent to this question offered some new information. First, he said that he had never been physically forced to comply with the medication order. Consequences would include losing privileges including smoking and participation in group activities. During the interview, he revealed that he had been hospitalized at VSH several other times and that during this hospitalization he experienced the staff differently. He said that in previous hospitalizations, he felt he had been “manhandled” and ended up in restraints. In this recent hospitalization he had had altercations with other patients. However staff treated him differently. He was put in the seclusion room, but he was not held down or restrained as he had been in the past. He also reported that staff – especially the psychiatric technicians and nurses aides— “seemed more friendly this time around...(they were) more careful...about jokes they made about crazy people – more cautious, less likely to want to restrain people than in the past”. He said that as a result of the changed staff attitudes, “I didn't want to challenge people as much as in the past”.

Problems and benefits resulting from court-ordered involuntary medication

People were asked to talk about what was difficult and/or unhelpful and what was helpful in the process of receiving involuntary medication.

One respondent reiterated that his doctor was not open to his suggestions to help him feel more comfortable and this made him realize that the doctor's “opinion counted and mine didn't”. Another person reiterated the difficulty caused by the side effects of the medication he was ordered to take, specifically the lethargy and lack of energy that made him want to sleep. A third person said, “The experience was a trauma – I was kidnapped from my apartment” and taken to the state hospital.

Two people did report experiencing benefits as a result of receiving involuntary medication. One person provided a detailed report. First, he reiterated that the psychiatric technicians were very helpful and supportive during his hospitalization. He felt they listened to his opinions and were supportive. Toward the end of the interview, he said, “I'm glad that I was medicated – it had a big impact on me.” He is living in the community now and reports that he continues taking medication. He understands that taking medication prevents aggressive, violent episodes.

Another respondent reported he knows he needed the medication at the time and felt positive about the fact that staff were familiar with his health records and subsequently used that information to find medicine that was beneficial for him.

Suggestions for improvements for administering involuntary medication

Respondents offered the following suggestions:

- “On an individual basis the patient should be listened to more about their complaints (especially about) side effects”
- “Patients should have more input, regardless of whether they are forced”
- There should be consequences for refusing to comply with medication orders – “this should be kept the same.”
- Set goals for people – “I’d tell the person that if they take this medication within a limited time they would be leaving VSH”
- “Patients should have a right to refuse.”
- “Explain to people why they are receiving the medication and give this to them on a piece of paper.”
- “The court people who order medication should try it so they understand the effects of the medication on them.”

Key Findings Emerging from Interviews

It is important to offer the following information about the interviews. First, the people who volunteered to participate in the interviews were self-selected. Therefore, one cannot view the findings as representative of all people who received Act 114 court-ordered involuntary medication in 2005. Rather, the reader can view these as “suggestive.” Second, in some cases, people were unwilling to comment on, or unable to remember, some of the circumstances surrounding the court order and administration of medication.

A number of significant findings emerged from these interviews, reflecting changes in perceptions and attitudes between people interviewed in 2003 and 2004 and people interviewed in 2005. As a result, the responses of 2005 interviewees to the interview questions:

1. Suggest that VSH has worked with some success to address several of the recommendations made in the 2004 evaluation; and
2. Provide guidance on areas where VSH staff should continue to improve the way in which it addresses the Act 114 policy and protocols.

The findings follow:

- One out of the four respondents expressed strong anger about the involuntary medication process as he experienced it. A second person felt he had not been listened to in terms of his concerns over medication side effects. However, two of the four reported they had been treated well and understood the benefits of having received involuntary medication. This represents an improvement in the way respondents felt from previous years.
- Interview participants were mixed regarding their individual sense of having control over any part of the process leading up to, during, or after receiving the

court order and subsequent medication. This is a change from the 2003 and 2004 responses, in which people consistently expressed their feeling of having no control over any part of the Act 114 process.

- In 2004 respondents reported feeling coerced by threats of not getting out of the hospital unless they took medication. Coercion was not reported uniformly by the 2005 respondents.
- As with 2004, this year's interview participants reported having received no information regarding the protocols governing the implementation of Act 114. Again, respondents were ignorant regarding their right to request a support person to be with them when medication was administered and regarding the fact that a written protocol exists.
- Half of the 2005 interview participants reported feeling they had been treated with respect. Again, this is in sharp contrast to 2004 respondents, who uniformly expressed their feelings that their health, dignity and respect were not insured.

Steps to Achieve a Non-Coercive Mental Health System

The Division of Mental Health (DMH) administrative staff identified several efforts to create a mental health system free of coercion. The goal underlying all of these strategies is to promote recovery, restoring self-determination and assisting individuals to remain in control of their own lives.

Vermont State Hospital Efforts

Time to Treatment

As outlined in the 2004 assessment, VSH was seeking to decrease the time it took to file orders for non-emergency involuntary medication in order to speed up the administration of medication, and thus reduce the length of stay at the hospital. Data from 2002 through 2004 indicated that this shift had occurred, with shorter time periods between admission and petition, and reduced lengths of stay indicating that VSH was moving toward more quickly providing involuntary medication to patients resulting in shorter lengths of stay.

This trend continued into 2005: the time between admission and filing petitions for court orders had gone from an average of 90 days in 2004 to 80 days in 2005. The time between admission and court decision had remained steady at an average of 109 days. This is because the time between filing and court decision had increased from an average of 19 days in 2004 to an average of 27 days in 2005.

Although VSH patients receiving involuntary medication under Act 114 had notably longer stays at VSH than other patients, this difference did decline in 2005 as compared to 2004. In 2005, Act 114 patients had 3.5 longer stays at VSH than other patients; in 2004, the Act 114 patients' length of stay declined to 3 times longer average stays than other patients.

Patient Involvement in Treatment Planning

Efforts continue to involve patients directly in monthly treatment planning meetings. As noted above, the majority of patients receiving involuntary medication under Act 114 in 2005 were directly involved in the treatment planning meeting, and nearly all were at least indirectly involved.

Individualized Emergency Plan

During the 2004 assessment, VSH staff reported that each person entering the hospital discussed what he or she would want to be done in case of an emergency, and from this an Individualized Treatment Plan was developed. The goal of these plans was to reduce the use of involuntary procedures through improved prevention. As described above, the Nursing Assessment includes relevant questions, but there is no evidence of a clearly articulated Emergency Treatment Plan included in the Treatment Plan.

Certificate of Need (CON)

As previously described, VSH developed and implemented utilization of a new CON form at the end of 2004. The goal was for this new form to improve data collection and create more consistency in practice. As planned, staff members did receive training on the use of the new form. The new form, as well as training and staffing patterns, has resulted in decreased use of emergency involuntary procedures (see previous discussion of Table 3). VSH staff report that Vermont's EIP data compare very favorably with other states. As reported by VSH staff, in past years, Vermont's use of restraints per patient hour was on average higher than other states. As of 2005, Vermont's mean was well below the average across the rest of the nation. VSH staff note that, unlike other state hospitals, VSH serves a range of patients including those in acute states and forensic patients. This means VSH, as compared to other state hospitals, is more likely to have the most difficult-to-serve patients.

Patient Report Card

Vermont Psychiatric Survivors (VPS) continue to provide VSH with a Report Card based on patient input. At discharge, social workers give patients Report Cards to complete and return to VPS using a stamped envelope provided. Overall, patient input has been positive; when problems are identified the information is used to identify training issues or staffing issues.

Patient Focus Groups

Two or three members of the Adult Mental Health Standing Committee come to VSH to meet with patients. These groups were in place during 2004, and during 2005 were held on a regular monthly basis. During 2005, the groups spent a good deal of time discussing renovations, including quiet rooms. The input from the groups goes directly to the Standing Committee. Input has led to changes in access to activities, facilities such as the yard and library, and increases in choices given the context of the hospital.

Peer Review Following Emergency Involuntary Procedures (EIP)

The 2004 assessment found that VSH was working toward including a Peer Review component of the debriefing process following use of EIP. This process is still in development for use of non-emergency involuntary medication. There is a Peer Review process in place for every CON.

Clinical Systems Improvement Workshops

During 2004, Clinical Systems Improvement (CSI) Workshops were instituted to improve the overall system at VSH. During 2005, several CSI workshops were held specifically addressing issues of coercion. There is now a monthly meeting of the Emergency Involuntary Procedure Reduction Program. Included in this meeting are VSH staff, a VPS representative and a Vermont Protection and Advocacy representative. This monthly meeting reviews EIP data, discusses decisions with treatment team members, and comes to a clear understanding of alternatives attempted and reasons for use of EIP.

The Treatment Review Panel meets quarterly to review the use of IEP. As reported earlier, their report indicates that the use of IEP has decreased in 2005 as compared to previous years.

CSI workshops have also addressed treatment planning, including feedback loops, active decision making, and meeting schedules. Non-aggressive Physical and Psychological Interventions (NAPPI) training is provided to all staff on a monthly basis.

Policy Changes

VSH and DMH staff worked with Vermont Legal Aid staff to revise the EIP policies. The focus was on updating policies to include national standards and best practices. This revision has been completed and is in place.

Over the past few years, the patient representative at VSH has been the Quality Manager, who is a state employee. VSH has been asked to have a non-state employee serve in this role, and has begun to talk with VPS about providing a representative. VPS is interested in the role of patient representative. In the coming year, VSH expects to develop a contract with VPS so that they will provide an independent patient representative for VSH patients.

In 2005, VSH instituted a policy that requires physicians to make an active determination as to whether or not restraints are needed to transport a patient to the hospital. In the past, the assumption was that if a person needed to be returned to the hospital, the Sheriff would automatically be called, and would transport the person using metal hand-cuffs. Now, the assumption is that persons do not require such restraint in transportation. VSH takes responsibility for returning persons to the hospital if they do not require restraint. Sheriffs are called only if the doctor has determined that the person requires restraint. Moreover, all sheriffs have been provided with non-metal handcuffs and have been encouraged to use them to transport persons with mental illness. As noted, below, DMH has made a similar shift in its policy regarding the transport of children, and anticipates funding in the FY 2007 budget to provide the same policy for adults.

DMH Community Efforts

Transporting Persons

As noted above, VSH no longer assumes that persons needing to be transported back to the hospital require restraint. Similarly, in 2005, DMH instituted a policy that alternatives to a sheriff must be explored for children; if a child presents a significant risk, than a sheriff will be asked to provide transportation. DMH has purchased and distributed to all sheriff's departments non-metal restraints to be used when transporting persons with mental illness. DMH has also requested an appropriation in the FY 2007 budget that would enable the use of alternative transportation for adults as well as children.

Recovery Education

DMH continues to support Recovery Education in both community and hospital-based mental health services. VPS participates in orientation of all new VSH staff members. Training emphasizes partnership with patients on their recovery, with a focus on strengths. In the community, DMH has been working to establish improved collaboration between the department and the recovery peer community. DMH would like to see increased funding for peer support.

VSH Futures

DMH, VSH and many stakeholders have been involved in developing plans for the future of mental health care for some time. One key area of this planning has been toward creating sub-acute, community-based residential recovery and treatment programs to serve people currently at VSH. This type of facility would represent an intermediate step that is not currently available in Vermont. The hope is that if individuals have this type of option, they will more likely voluntarily participate in treatment rather than be involuntarily hospitalized at VSH. At present, the plan is to develop two sites, able to serve 16 to 18 persons at one time.

In addition, DMH and VSH are working toward building a new inpatient hospital facility to replace VSH. Consumers are actively involved in creating designs for the physical plant, so that the space enables staff to offer alternatives to involuntary procedures, such as crisis stabilization beds, step-down beds, and options to be with peers. The goal is to develop a secure environment that is welcoming and does not feel confining.

Community Hospitals

Presently, all forensic patients are served at VSH. Community hospitals, in addition to VSH, are being designated to serve forensic patients. At the end of 2005, two general hospitals had been designated, and two more were expected to be in place during 2006. The Commissioner of Health now has the option to place forensic patients in less intensive community hospitals than VSH.

In addition, DMH is working with community hospitals to minimize the use of conditional voluntary admissions. Conditional voluntary admission enables hospitals to admit patients and then hold them up to four days after they have asked to leave. The goal is to have hospitals provide more truly voluntary admissions and treatment. In the past, some community hospitals have admitted individuals only on a conditional voluntary basis. If this is the only route into community hospital psychiatric care, it prevents the system from offering a range of alternatives. Thus, DMH seeks to expand the options for treatment in community-based hospitals.

Outcomes from Implementation of Act 114

The 2004 assessment identified, through stakeholder input, a set of outcomes that would be expected with successful implementation of Act 114. These outcomes include:

- VSH staff are aware of Act 114 provisions
- Decreased length of time between hospital admission and filing petition for involuntary medication
- Decreased length of stay at VSH for persons receiving involuntary medication
- Reduced readmission rates and increased length of community stay for persons receiving involuntary medication
- Satisfaction with non-emergency involuntary medication process among patients, family members, and VSH staff

We have been able to assess achievement of all but one of these outcomes. The one outcome for which data were not available was readmission and community stay. Evidence for the remaining four outcomes indicates:

- VSH staff are aware of Act 114 provisions as shown by (a) documentation of adherence to Act 114 provisions, and (b) responses to interview questions.
- From 2004 to 2005, the length of time between VSH hospital admission and filing petitions for involuntary medication has decreased as evidenced by DMH tracking data.
- Persons receiving involuntary medication under Act 114 experienced a shorter length of stay at VSH in 2005 than in previous years, again evidenced by DMH tracking data.
- VSH staff generally express satisfaction with the provisions of Act 114, although they would like the process to move more quickly.

Recommendations

It is important to acknowledge that the evidence drawn from all data sources strongly suggest that VSH administration and staff have seriously attended to the recommendations posed in the 2003 and 2004 evaluations of the implementation of Act 114. There has been a clear change in the methods, frequency, and quality of documentation of the hospital staff's adherence to the protocols of Act 114. Hospital records demonstrate that VSH staff are attending to the protocols defined in the legislation.

Interviews with persons who received involuntary medication under Act 114 during 2005 demonstrate a decreasing rate of negative experience associated with receiving involuntary medication under Act 114. This is not to say that all problems have been eliminated. But the tone of responses from those persons suggests that positive changes are occurring in the following ways:

1. a perceived positive change in the attitudes of staff towards patients
2. an acknowledgement that some people felt they had a level of input into their care
3. a recognition that receiving involuntary medication was, in the long run, beneficial to certain patients as it allowed them to reenter the community and maintain a desirable lifestyle

There are still areas where patient reports and staff reports and documentation are at odds with each other. Therefore, we acknowledge the progress that VSH staff has made and encourage them to continue efforts to adhere to the components of Act 114 through the following recommendations:

- Patients are informed of and understand the Act 114 Protocols. The VSH patient orientation handbook, while complete, may be too difficult to read or understand especially for people who may be confused when first entering VSH or during hospitalization. Therefore, alternative patient education efforts should be developed to make sure that patients understand the purpose of the law and the protocols that VSH staff must follow in seeking and implementing an involuntary medication court order. How this information is delivered and communicated is as important as what is communicated - the information should be delivered to patients in a way that is perceived as non-judgmental, not arbitrary and not coercive.
- Consumer-advocates play a role in educating people. VSH may want to consider having consumer-advocates from organizations such as Vermont Psychiatric Survivors meet with patients individually for the purpose of educating people about Act 114 through discussion versus through reading. In order to insure that each person fully comprehends the law, it may be necessary to meet more than once with any patient to review and clarify the law and answer questions. This may be a role for the Patient Representative.

- Approaches should be adopted to insure that people are apprised of and fully understand their rights, including:
 - the right to be at their own hearing in court
 - the right to have a friend, advocate or family member present at the court hearing who can support them and speak for them
 - the right to have a support person present when receiving medication
 - the right to file a grievance.
- VSH staff should make continued efforts to help patients understand the reasoning behind the decision to seek an involuntary medication order. Within the existing protocol, definitions should be clear regarding what behaviors and conditions would lead to court-ordered involuntary medication being sought. These definitions should be reviewed with patients through means that will leave patients informed.

Recommendation for reducing the use of coercion and increasing voluntary participation of consumers in Vermont's mental health system services:

- In order to facilitate active discussion and development of Individualized Emergency Plans for patients entering VSH, the Treatment Plan form should be modified to include a section on emergency planning. This section should include information on whether or not the patient already has an emergency plan, along with specifics on that plan. It should also include whether or not the initial Nursing Assessment was able to address emergency issues, and if so, specifics shared by the patient.
- Resources for language interpreters should be developed so that patients who do not speak English will have full access to involvement in nursing assessments, treatment planning, and other key points in the service system.
- Continue efforts to create a mental-health system that includes a wide range of treatment options.
- Continue efforts to bring non-emergency involuntary medication into community hospital settings in order to enable persons to remain closer to home communities.
- Continue efforts to give patients a greater sense of control over whether and how involuntary medication will be administered to them. Treatment planning should address ways that the time between petitioning for a court order and granting of the order could be used to work with the patient to develop options and set clear behavioral objectives that, if met, could avoid the need for involuntary medication.

Recommendations for the annual assessment of Act 114

- Structure the annual independent assessment of Act 114 to be conducted in an ongoing manner that is guided by clear action plans, timelines, and agreements between the assessors and participating entities. In 2004, recommendations were made to have the Mental Health Law Project contact persons medicated under Act 114 within 4 weeks of their release from VSH. Contractual agreements between the Division of Mental Health and the consultants hired to conduct the evaluation were not completed until the end of June. If contracting with evaluators can be completed earlier in 2006 and subsequent years, the following recommendations can be implemented, with the intention of gathering feedback from a larger group of individuals who received involuntary medication under the provisions of Act 114:
 - MHLPP should send packets to persons who were medicated under Act 114. Sending a packet within a few weeks of one's release date will reduce the likelihood of losing contact with people who may eventually move
 - MHLPP should send out follow-up letters within another specified time-frame after the first letter.
- Recognizing that persons receiving involuntary medication may stay at the state hospital for long periods of time, MHLPP should also continue its current practice of contacting persons who received involuntary medication under Act 114 and who still reside at VSH
- Continue current methods of recruiting participation of persons and families in the Act 114 evaluation. Continue to engage peers and advocates to assist in recruiting persons that have received non-emergency involuntary medications to participate in the assessment interviews through VPS. The significant increase in the rate of patient participation from the 2004 to 2005 evaluation suggests that future evaluation efforts continue to utilize the recruitment methods used in 2005 which are described on page 12 of this report. In particular, the inclusion of a consumer-advocate, who is known and trusted throughout the mental-health consumer community, who is available through a toll-free number, and who provides initial information, was key to increasing participation.
- Continue to provide financial incentive for participation.
- Continue to gather and manage information that allows assessment of outcomes to determine impact of Act 114 implementation, including
 - VSH staff knowledge of Act 114 provisions
 - Length of time between hospital admission and filing petition for involuntary medication
 - Length of stay at VSH for persons receiving involuntary medication
 - Satisfaction with non-emergency involuntary medication process among patients, family members, and VSH staff

- Initiate data collection and management efforts which enable assessment of the following Act 114 implementation outcome:
 - Readmission rates and length of community stay for persons receiving involuntary medication

Conclusion

Vermont State Hospital uses written protocols and record-keeping forms to guide adherence to the provisions of Act 114. The 2004 assessment found that documentation was incomplete and in need of improvement. This 2005 assessment found that VSH has significantly improved its documentation of Act 114 implementation. Indeed, documentation was quite thorough and indicated that all provisions of Act 114 were implemented.

The time between hospital admission and filing petitions for non-emergency involuntary medication continued to decrease, thus VSH has continued to improve its time to providing treatment. This also appears to be resulting in shorter periods of hospitalization. Nevertheless, VSH staff would like the process to move even more quickly as they believe patients suffer on many levels when not receiving treatment. VSH staff members continue to see use of involuntary medication as a last resort and vastly prefer to engage patients in voluntary treatment.

Persons who received involuntary medication under Act 114 in 2005 who responded to interviews had mixed reactions to the benefits of getting medication in this manner. There is a sense that staff attitudes, perhaps resulting from ongoing training and reduced staff-to-patient ratios, have improved and are resulting in better outcomes for patients. However, it is also clear that staff need to work diligently--and perhaps in concert with advocates and peers--to find effective ways to make patients aware of:

- Protocols laid out in the law
- Patients' rights
- Ways to exercise their rights.

The continuing challenge is to build a mental-health system that provides a broad array of service options, primarily in community-based settings. All stakeholders agree that a range of options is essential to creating a non-coercive mental health system.